WORKERS' COMPENSATION TEMPORARY/MODIFIED ALTERNATE DUTY AGREEMENT FORM

CAMPUS NAME

Employee Name: ________________________________ Date of Injury/Onset of Illness: ___________________
Job Title: ______________________________________ Supervisor Name: ___________________________
Department: ______________________ Date Assigned to Temporary Light Duty by Physician: _____________
Light Duty Start Date: ___________________________ Light Duty End Date: ___________________________

Description of Work Restrictions, per Treating Physician: (List specifically what is stated in medical note.)

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Assignment Type: ☐ Modified ☐ Alternate* (Temporary work in another position and/or location)

*If Alternative location, Supervisor's Name: _________________ Alternative location: ______________________

Description of Accommodation(s) Offered: ____

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Work schedule: ☐ Unchanged ☐ Changed _____ Work hours per Day from ______am/pm to ____am/pm

Work Days: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

If assignment not available - Reason/Discussion Points: ____

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Employee may appeal the decision by contacting Risk Management at (619) 388-6953.

I agree to follow the work restrictions as prescribed above by my treating physician. I understand that I need to adhere to the agreed upon temporary restrictions and accommodations. I also understand that if I am asked to perform any work assignments or activities that exceed my work restrictions, I will immediately report the situation to my direct supervisor and that I will not perform these activities. Furthermore, I will immediately report to my direct supervisor if any of the work restriction(s)/accommodation(s) cause me discomfort or make my medical condition worse.

I understand that a temporary modified/alternate duty assignment will be periodically reviewed and will not normally exceed 60 calendar days, and does not imply entitlement to a permanently modified position. I also understand that it is my responsibility to provide my supervisor with current work status reports from my physician. This approval period ends ________________ and will not be extended unless I provide additional medical certification and unless there is a necessary assignment for me to perform that is within my restrictions.

Additional Comments/Notes: ____

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The work restrictions and accommodations were reviewed with the employee on: ___________________________

Employee's Signature: ____ Date: ____________________

Supervisor's Signature: ____ Date: ____________________

CC: Risk Management